School Health Profiles

South Dakota 2004 **Executive Summary**

Coordinated School Health Program

Departments of Education and Health

School Health Profiles
Executive Summary

Elementary and Secondary
2004

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"Because schools are the only institutions that can reach nearly all youth, they are in a unique position to improve both the education and health status of young people throughout the nation."
Carolyn Fisher et al., 2003

Introduction

Numerous individuals, organizations, and research reports have underscored the school's role in promoting health for students. For example, the Carnegie Foundation on Adolescent Development concluded that, "Schools could do more than perhaps any other single institution in society to help young people, and the adults they will become, to live healthier, longer, more satisfying, and more productive lives" (National Center for Chronic Disease Prevention and Health Promotion, 2004b, p. 1). The National Center for Chronic Disease Prevention and Health Promotion (2004b) also confirmed that numerous studies that have evaluated health education indicate that it is effective in preventing the adoption of many high-risk behaviors by youth and adolescents.

Organizations such as the American Association of School Administrators, American Cancer Society, Association for Supervision and Curriculum Development, and the National School Boards Association have emphasized the importance of comprehensive school health education (Lohrmann & Wooley, 1998). The U.S. Department of Health and Human Services' publication Healthy People 2010: Understanding and Improving Health (2000) includes the relevant goal of increasing the quality, availability, and effectiveness of educational and community-based programs designed to prevent disease and improve health and quality of life. The publication also articulates that, "Schools have more influence on the lives of young people than any other social institution except the family and provide a setting in which friendship networks develop, socialization occurs, and norms that govern behavior are developed and reinforced" (p. 7-4).

As schools alone cannot be expected to address the nation's most serious health and social problems, comprehensive school health represents one component of a more extensive coordinated school health program. The American Association for Health Education (2003) approved a position statement that identified the following elements of a coordinated health program: health education, physical education, health services, nutrition services, health promotion for staff, counseling and psychological services, healthy school environment, and parent/community involvement. Within the coordinated school health model, comprehensive school health education provides a planned, sequential, K-12 curriculum that addresses the physical, mental, emotional and social dimensions of health. The curriculum is designed to motivate and assist students to maintain and improve their health, prevent disease, and reduce health-related risk behaviors. It allows students to develop and demonstrate increasingly sophisticated health-related knowledge, attitudes, skills, and practices (National Center for Chronic Disease Prevention and Health Promotion, 2004a).

While school health education for children at all grade levels has been recognized as a national priority for some time (U. S. Department of Health and Human Services, 2000), the evidence suggest that many American students receive little or no health education on a regular basis (Seffrin, 1994). Moreover, the literature has identified concerns regarding the quality of health education that include inadequate pre-service teacher preparation and inservice training (Joint Committee of the Association for the Advancement of Health Education and the American School Health Association, 1992; Connell, Turner, & Mason, 1991), lack of state-required examinations for health education (Collins et al., 1995), and lack of administrative support for health education (Monhahan & Scheirer, 1988).

Elementary School Health Profile

PURPOSE OF THE STUDY

The purpose of the study was to assess the status of elementary health education in public, private, and Bureau of Indian Affairs (BIA)/tribal schools throughout South Dakota. The study was designed to provide current data collected from elementary school principals and teachers regarding curriculum coordination, content, and instructional techniques; identify perceptions of the importance and quality of elementary school health education; and assess professional preparation experiences and needs related to health education.

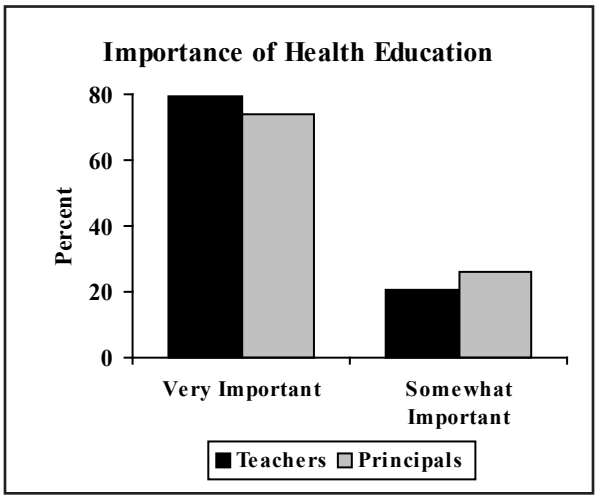
METHODOLOGY

Data for the study were collected using a mail survey of principals and teachers from public, private and BIA/tribal schools in South Dakota. A random sample of 750 elementary school teachers was selected that was comprised of 450 public, 150 private and 150 BIA/tribal school teachers. In addition, a random sample of 200 public school principals, as well as all private school principals (n=49) and BIA/tribal school principals (n=20) were selected for the study, producing a total sample of 269 principals. All surveys and follow-up surveys were mailed during spring 2004.

RESPONSE RATES

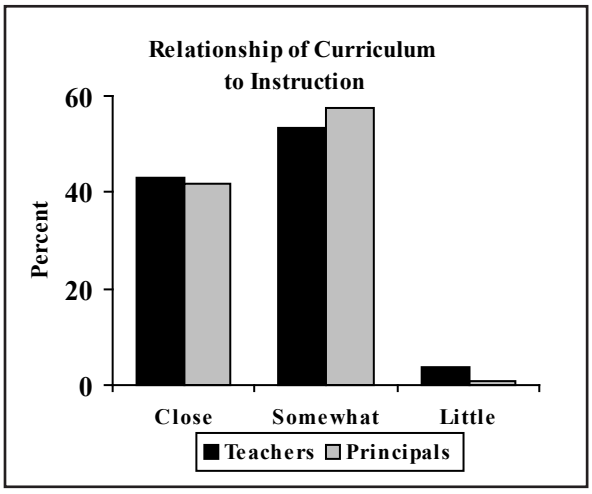
Usable questionnaires were received from 167 public school teachers (37.1%), 46 private school teachers (30.7%), and 42 BIA/tribal school teachers (28.0%). This produced a total of 255 completed surveys for an overall usable response rate of 34.0% from the teachers. Usable questionnaires also were received from 140 public school principals (70.7%), 38 private school principals (77.6%), and 13 BIA/tribal school principals (65.0%). This produced a total of 191 completed surveys for an overall usable response rate of 71.5% from the principals.

1. Elementary teachers and principals consider health education to be an important subject for students.



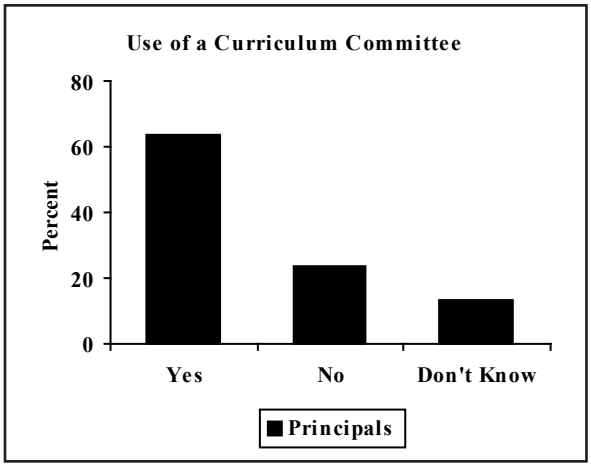
While teachers and principals from public, private, and BIA/tribal schools agree that health education is an important subject for students, private and BIA/tribal school principals consider health education to be more important relative to other academic subjects than do their public school counterparts. While a majority of public and private school teachers and principals agree that health education is more important than science, a much smaller number of them believe that health education is as important as language arts or math.

2. Health education curriculum implementation does not appear to be well integrated within the overall elementary curriculum.



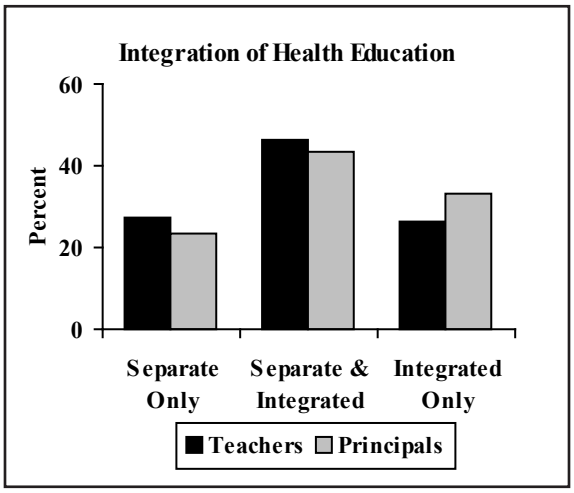
While most public and private schools have a written health education curriculum, many fewer BIA/tribal schools reported having a written health education curriculum. A much larger proportion of public school teachers and principals described their health education curriculum as being part of the K-12 curriculum than did their private and BIA/tribal school counterparts. Fewer than half the teachers and principals from public, private, and BIA/tribal schools reported that classroom instruction closely follows the curriculum. Most school districts use a health education curriculum that is a combination of a curriculum developed within the district and commercially prepared materials with Growing Healthy being the most commonly used commercially prepared program.

3. There is reasonably extensive stakeholder participation in the development or selection of the elementary health education curriculum.



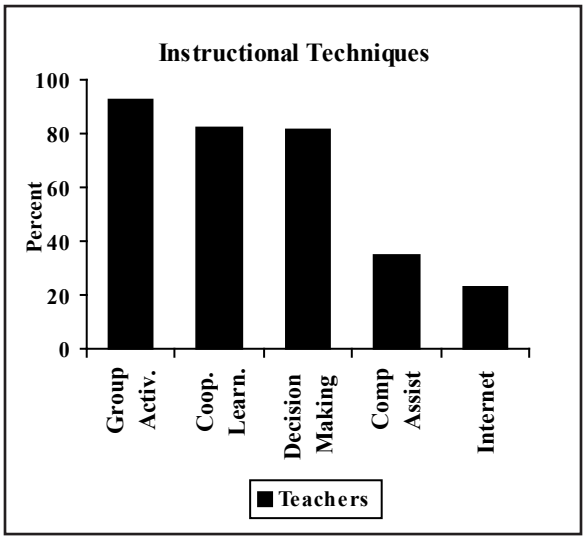
Most principals reported that a committee was used to develop or select the elementary health education curriculum for their district, and most teachers indicated that they had some level of involvement in the development of the health education curriculum for their school. Additionally, principals identified various stakeholders from school and the community as members of their health education curriculum committees. While nearly half the principals believe that teachers were provided with training designed to prepare them to implement the curriculum, fewer teachers indicated that they received such training.

4. Health education is generally taught as a separate subject that is also integrated with other subjects.



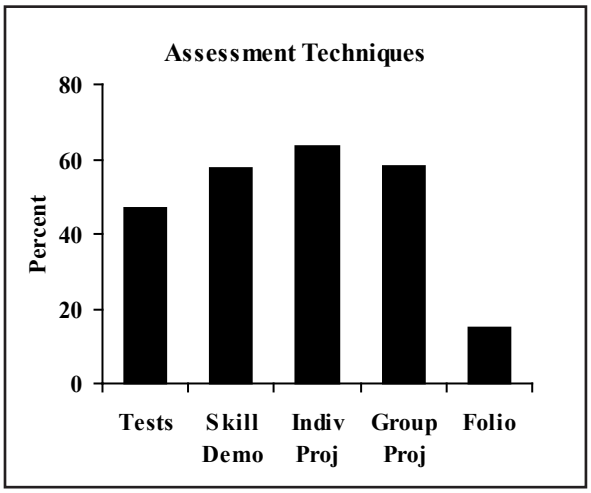
Most teachers indicated that in their schools, health was generally taught as a separate subject that was also integrated with other subjects. While most of the public and private school principals agreed with this assessment, BIA/tribal school principals felt that health was taught primarily integrated within other subjects such as physical education and science.

5. Most of the teachers use student-centered active instructional techniques, but not with computers, to address a variety of health education content areas.



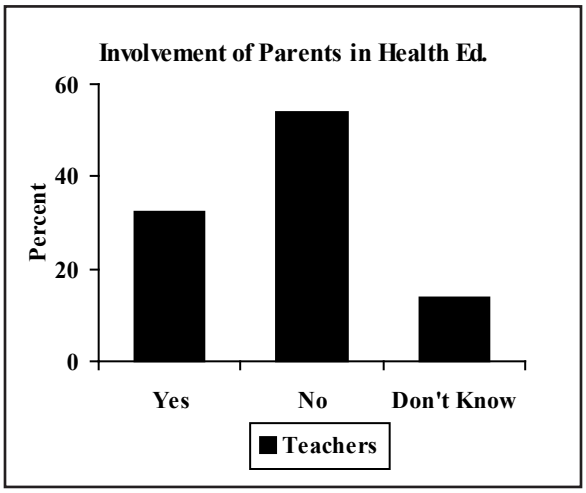
Most teachers reported using student-centered instructional activities such as group activities, cooperative learning, decision-making and problem-solving activities, role playing, value-related discussions, and hands-on activities. However, few teachers reported using computer-assisted or Internet learning. The most commonly taught health education content areas in 2002-2003 were designed to increase students' knowledge, attitudes, and skills related to nutrition and dietary patterns, alcohol and other drug use prevention, physical activity and fitness, unintentional injury prevention, tobacco use prevention, oral health, and environmental health.. The least commonly taught health education areas related to HIV and STDs, family life and sexuality, and intentional injury prevention (violence/suicide).

6. Many teachers use a variety of techniques for assessing student achievement in health education.



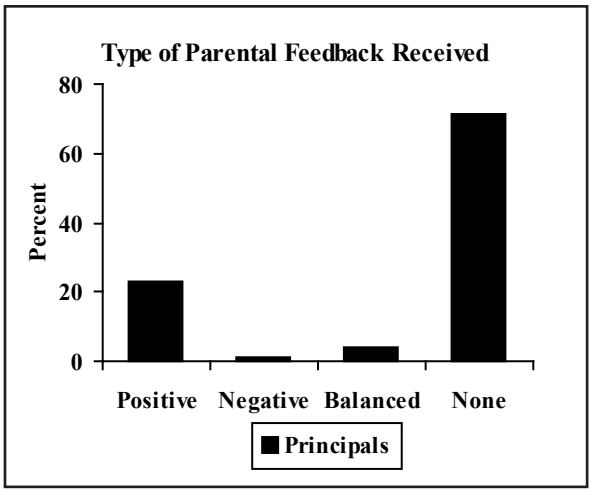
A majority of teachers reported using individual projects, skill demonstrations, and group projects for assessing student achievement in health education. Few teachers use student portfolios as a means of assessing student achievement. Additionally, few schools or school districts conduct any type of formal evaluation of the elementary school health education program.

7. Parents and community members are afforded few opportunities for involvement in elementary health education.



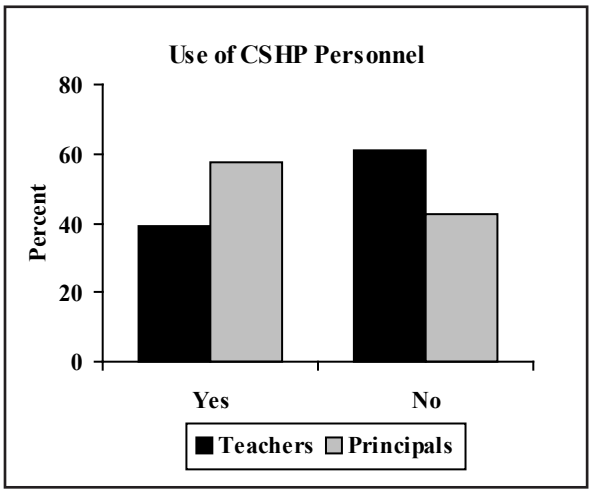
Few teachers reported attempting to involve parents in health education through presentations to parent groups or at-home cooperative learning activities. In addition, very few principals reported that their school had an advisory council or similar committee involved in health education-related decision- making.

8. There is limited two-way communications between schools and parents regarding elementary health education. However, more parental feedback regarding health education is positive than negative.



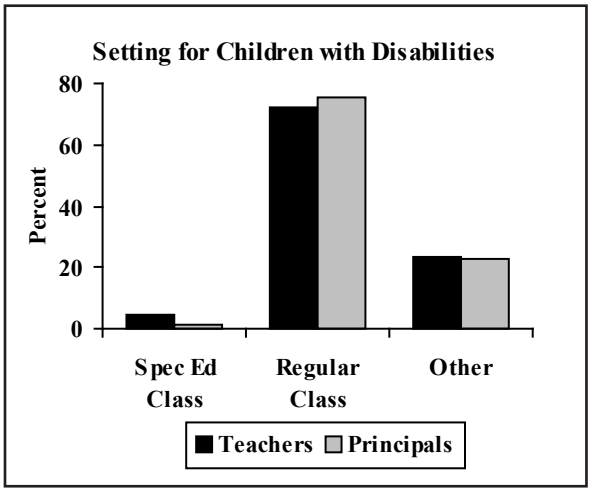
Few public, private, or BIA/tribal school principals report receiving any feedback from parents regarding the status of health education in their schools during the 2003-2004 school year. However, those receiving feedback reported it to be mainly positive. In addition, fewer than half the principals indicated that they kept parents apprised of their schools' health education program through school newsletters or local newspapers, radio, or television.

9. Teachers and principals disagree regarding the level of involvement of individuals representing components of the coordinated school health program with health education teachers in health-related projects and activities.



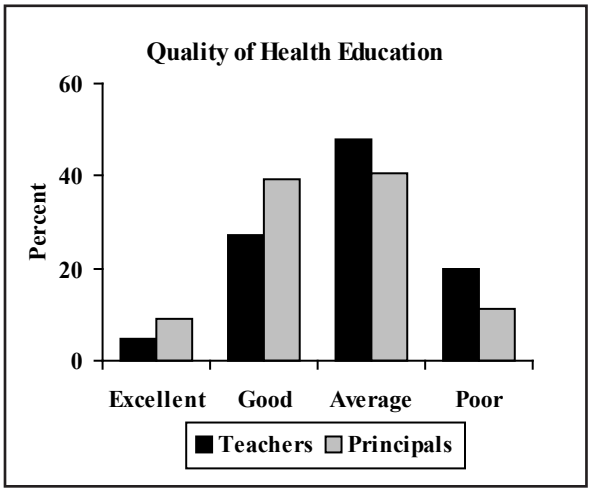
A minority of teachers reported organizing health-related projects or activities with individuals representing any components of the coordinated school health program (with a very few exceptions). In contrast, a majority of principals indicated that teachers organized projects and activities with a variety of individuals (including physical education teachers, school health service staff and school counselors/ psychologists) representing the coordinated school health program.

10. The majority of students with disabilities are provided health education within the regular classroom setting.



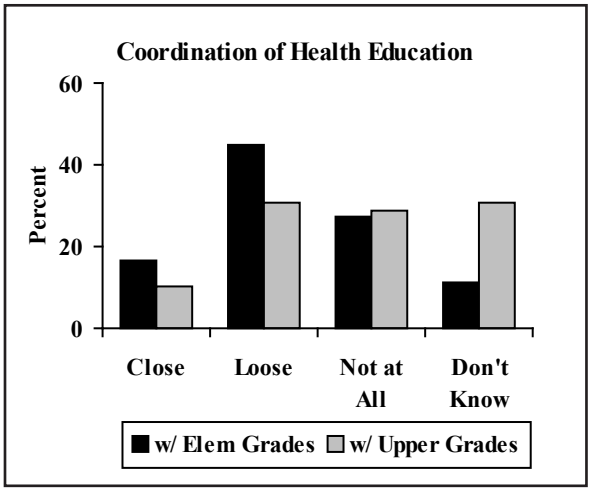
While principals reported to a much greater extent than their teachers that their school provides health education to students with disabilities, both groups agreed strongly that most students with disabilities receive health education within the regular classroom setting.

11. While most teachers and principals believe that their health education programs are good or average, very few teachers or principals consider their health education programs to be excellent.



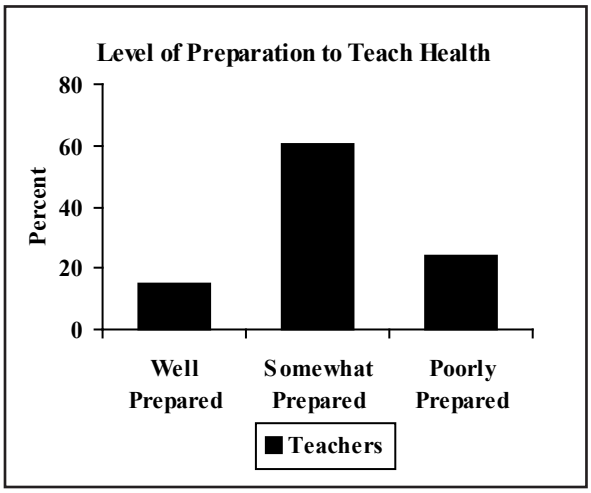
Similar proportions of public and private school principals believe their health education programs are either good or average. In contrast, public and private school teachers considered the quality of their health education programs to be no better than average. However, very few teachers or principals rated their health education programs as excellent. Teachers and principals at BIA/ tribal schools considered the quality of their health education programs to be mostly poor.

12. Health education programs are loosely coordinated among the elementary grade levels, and are loosely coordinated with health education programs at the middle and high school levels.



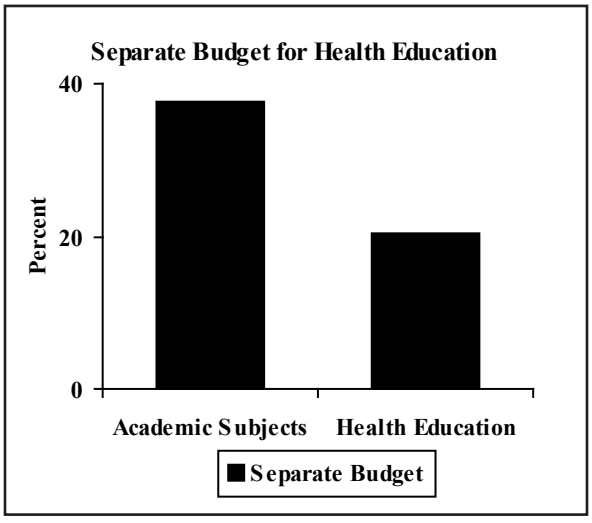
Most teachers and principals described their health education programs as being either loosely coordinated or not coordinated at all among the different grades within their elementary school. Similarly, most teachers and principals described their health education programs as either loosely coordinated or not coordinated at all with health education in their districts middle and/or high schools.

13. While most teachers consider themselves somewhat well prepared to teach health education, few teachers consider themselves well prepared or perceive that they receive adequate ongoing professional development.



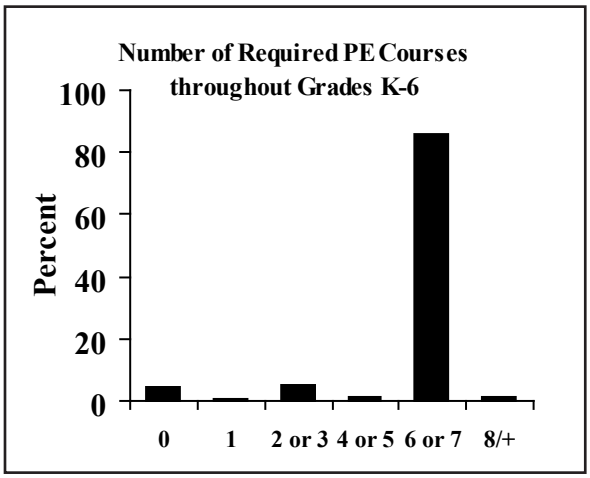
Most teachers reported having taken at least two health-related courses during their college training. However, most teachers had not attended a staff development workshop that focused on health education during the past two years, and very few had attended two or more workshops during that period. The inservice topics of greatest interest to teachers include conflict resolution skills, awareness of health education resources, health instructional strategies, nutrition and dietary patterns, and curriculum development strategies.

14. Few schools have a separate budget for health education.



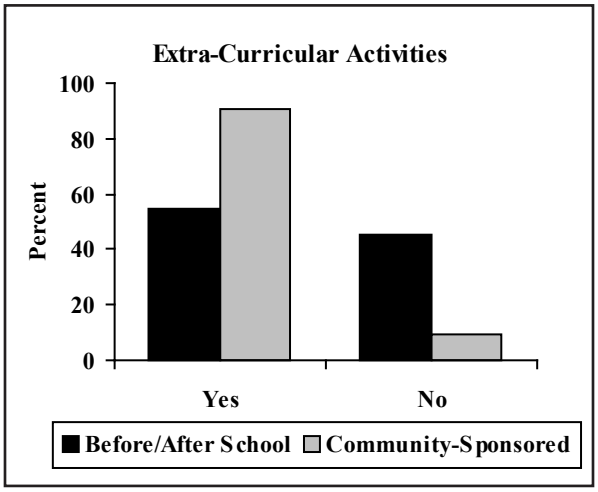
A majority of principals from public, private, and BIA/tribal schools reported that there is less likely to be a separate budget for health education than for other academic subjects in the school. About one-fourth of the public school principals and even fewer private and BIA/tribal school principals indicated they had a separate health education budget.

15. Most students participate in required physical education courses on a regular basis throughout their elementary school programs.



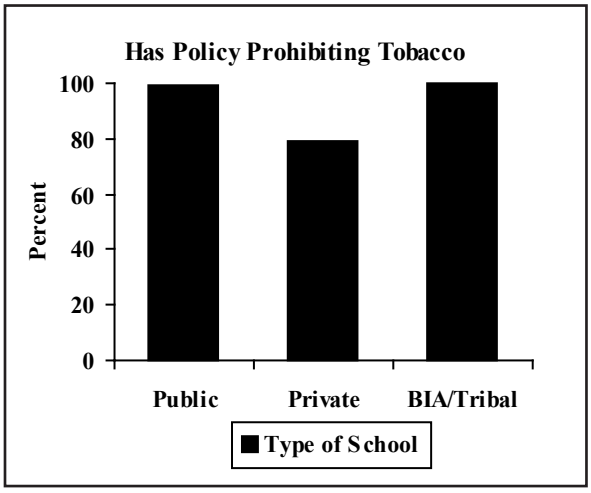
The majority of principals reported that their students take six or seven required physical education courses throughout their K-6 educational programs. Principals also indicated that students generally attend physical education classes from one to three days per week for 30 to 40 minutes per class period, with the upper grade-level students attending slightly more frequently for longer periods of time.

16. Elementary schools provide extensive opportunities for children and adolescents to utilize their facilities for physical activities and sports outside of normal school hours.



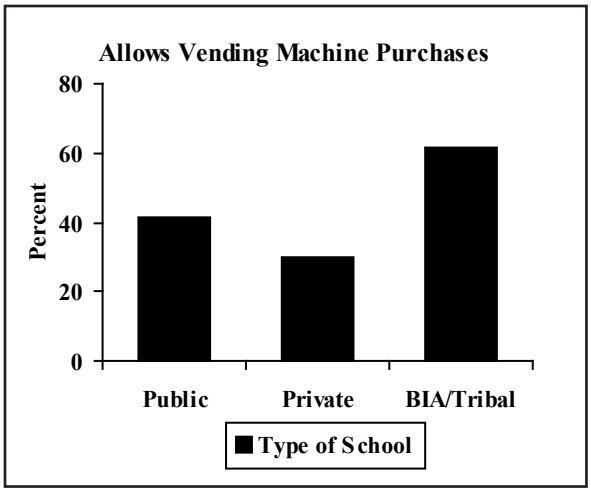
The majority of principals stated that their schools offer students opportunities to participate in before-school or after-school intramural activities or physical education clubs. Also, most principals admitted that children or adolescents use their schools' physical education or athletic facilities for community-sponsored sports teams or physical activities outside of school hours or when school is not in session.

17. Nearly every elementary school has a tobacco prevention policy that is strictly enforced for students; however, the policies are less rigorous toward faculty, staff, and visitors, and less strictly enforced outside of school buildings and vehicles.



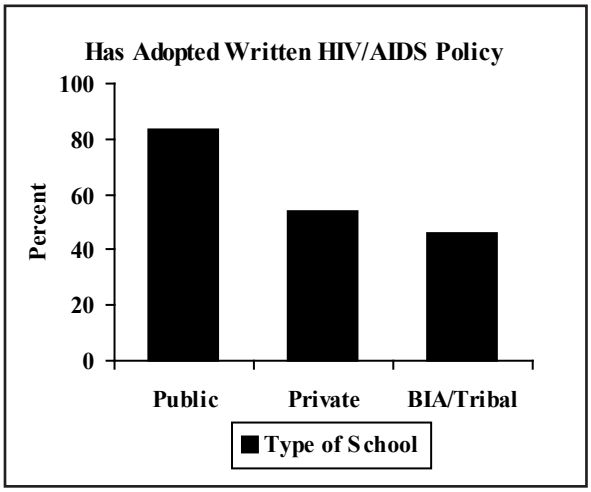
Nearly every principal indicated that their school has adopted a tobacco prevention policy that prohibits students from using tobacco in school buildings, on school grounds, in school buses and other transport vehicles, and at off-campus, school-sponsored events. While these policies prohibit faculty, staff, and visitors from using tobacco in school buildings and in school vehicles, there are fewer restrictions regarding tobacco use by these groups on school grounds and at off-campus, school-sponsored events. The principal and other teachers and staff have primarily responsibility for tobacco use policy enforcement at almost every school.

18. Students' ability to purchase snack foods and beverages from vending machines remains limited within elementary school facilities.



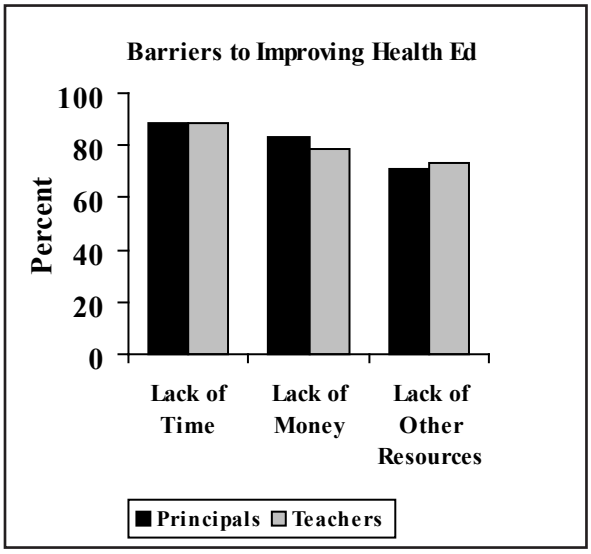
Slightly less than half the elementary principals (on average) reported that their students could purchase snack foods or beverages from vending machines at the school store, canteen, or snack bar. While bottled water and other beverages are most commonly available for purchase from vending machines by elementary school students, fresh fruit and vegetables as well as baked goods and salty snacks that are not low in fat are least available.

19. Public elementary schools are more likely than private or BIA/tribal schools to have adopted written policy that protects the rights of students and/or staff with HIV infection or AIDS.



While most public elementary school principals indicated having adopted written HIV policies, only about half of their private and BIA/tribal counterparts admitted that their schools had done the same.

20. Lack of instruction time and resources are the greatest barriers to improving health education in South Dakota schools.



Principals and teachers cited lack of instructional time and monetary and non-monetary resources as the greatest barriers to improving health education in their school. Lack of school district and administrative support was considered much less of a major barrier by principals and teachers.

1. **Conduct activities designed to inform educators of the school's role in promoting health for children and to promote the development and implementation of a comprehensive K-12 health education curriculum in South Dakota school districts.** These activities should include (but not necessarily be limited to):

    - dissemination of information to educational administrators and practitioners that underscores the importance of the school's role in promoting health for children and the relationship of an effective comprehensive school health program to the overall health of its children.

    - training for school administrators and policymakers that highlights the importance of integrating health education into the broader K-12 curriculum and presents a model or mechanism for the successful integration of health education into the K-12 curriculum.

    - the development or adoption of a specific model for development and implementation of a comprehensive health education curriculum.

    - training for school district teams of administrators, teachers, and other staff that focuses on appropriate utilization of the health education curriculum model.

2. **Provide professional development for teachers that focuses on topics teachers identify as being of greatest interest.** Teachers in the present study identified conflict resolution skills, awareness of health education resources, health instructional strategies, nutrition and dietary patterns, and curriculum development strategies as the professional development topics of greatest interest. Professional development activities highlighting these topics should be developed and provided for the greatest number of health educators possible throughout the state. Results of the present study should also be examined for the possibility of providing differentiated professional development for public, private, and BIA/tribal school teachers based on specific areas of interest to teachers within each of these different groups.

3. **Develop and disseminate a model for effective two-way communication and involvement of parents and community members in their local elementary health education programs.** Conduct meetings with school administrators, teachers, parents, and local community members that highlight the importance of open, two-way communications and parental and community member involvement in the health education program within their local schools. Provide a model or mechanism by which such involvement may be accomplished.

4. **Provide professional development opportunities that focus on the importance and potential benefits of involving individuals representing components of the coordinated school health program in classroom health education instruction.** Conduct meetings or inservice activities for school administrators, teachers, and individuals representing components of the coordinated school health program that highlight the importance and potential benefits of involving these individuals in classroom health education instruction. Provide a model or mechanism by which administrators and teachers can effectively incorporate the expertise and services of individuals representing components of the coordinated school health program into the health education program.

5. **Provide professional development activities for teachers that focus on the integration of technology into health education instruction.** Conduct inservice activities for teachers that enhance their awareness of the technology available to assist them in health education instruction and assist teachers in effectively integrating the technology that is available.

6. **Provide professional development and technical assistance to promote evaluation of school health education programs.** Conduct inservice activities for school administrators and teachers that highlight the importance of continuous evaluation of school health education programs and the benefit of data-driven decision-making approaches. Provide a model or mechanism by which districts and schools can effectively evaluate their health education programs and implement needed changes identified through the evaluation process.

7. **Provide current information regarding the risks associated with lack of physical exercise, tobacco use, poor nutritional habits, and HIV infection, and provide strategies and materials for school administrators and teachers that assist them in disseminating this information to students.** Materials depicting the most current information regarding potential dangers associated with lack of physical exercise, tobacco use, poor nutrition, and sexually-transmitted diseases should be widely disseminated to school administrators and teachers to enable them to address these issues with their students, parents, and community members. This information and strategies to assist children to select more healthy lifestyles should be incorporated both within the curriculum and within the general culture of the school.

8. **Recognize schools that provide adequate physical education classes and opportunities for out-of-school physical activities and encourage other schools to make more opportunities available for their students and community members.** The state should recognize the many schools that, based on study results, already offer opportunities to children and adolescents to participate in regularly scheduled physical education classes and out-of-school activities. At the same time, the state should encourage these schools to enhance these opportunities and induce schools not offering such opportunities to begin doing so.

9. **Provide assistance to school administrators and teachers in addressing the problem of lack of instructional time for including health education in the school's instructional program.** Conduct professional activities for school administrators and teachers that focus on alternative models for planning and scheduling classes that provide sufficient time for health education instruction.

10. **Provide adequate resources for targeted improvements in school health education programs.** The state must provide sufficient resources in the form of grants, loans, funding, and up-to-date curricular materials to enable schools and districts to implement the programs and activities presented through professional development activities. Both monetary and non-monetary resources must be provided to meet the diverse needs of school administrators and teachers in public, private, and BIA/tribal schools throughout South Dakota.

Secondary School Health Profile

PURPOSE OF THE STUDY

The purpose of the study was to monitor characteristics of health education in secondary public, private, and Bureau of Indian Affairs (BIA)/tribal schools throughout South Dakota. The study was designed to provide current data regarding health education requirements, coordination of health education, parental feedback, tobacco use policies, violence prevention activities, and HIV policies in South Dakota secondary schools.

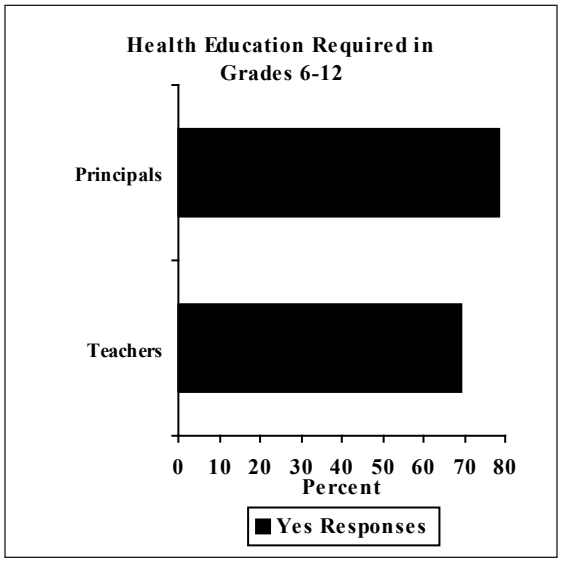
METHODOLOGY

Data for the study were collected using a mail survey of principals and lead health teachers from junior high, middle, and senior high schools in South Dakota. A random sample of 264 principals was selected for the study, and each of the principals selected to participate in the study was requested to distribute a secondary teacher survey and cover letter to the lead health education teacher within their building, producing a sample of 264 teachers. All surveys and follow-up surveys were mailed during spring 2004.

RESPONSE RATES

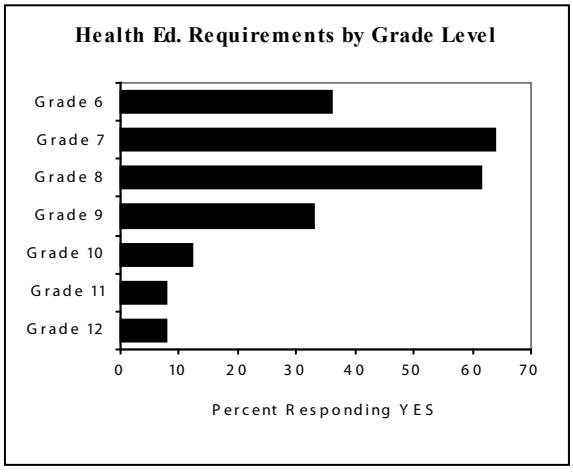
Usable surveys were received from 148 secondary school principals representing an overall usable response rate of 56.1% from the secondary school principals selected to participate in the study. Usable surveys also were received from 105 secondary school teachers yielding an overall usable response rate of 39.8% of the secondary school lead health education teachers selected to participate in the study.

1. Most students throughout South Dakota are required to take at least some health education during their secondary education (grades 6 through 12).



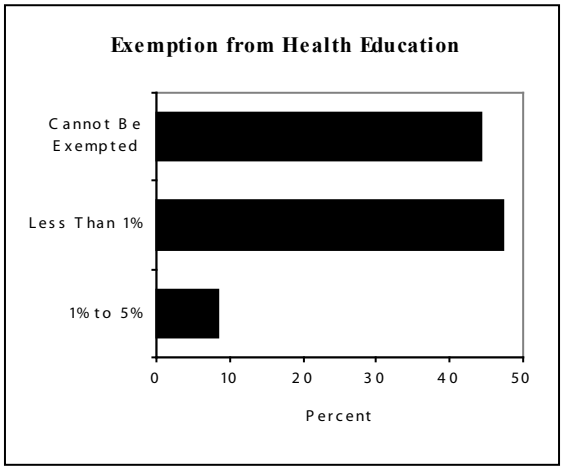
Approximately three-fourths of the teachers and principals indicated that students in their schools are required to take at least one health education course during grades 6 through 12. While nearly one-third of all schools require students to take only one health education course, nearly half of the schools require students to take two or three health education courses.

2. Required health education courses are most prevalent during the junior high/middle school grades and diminish progressively throughout the high school grade levels.



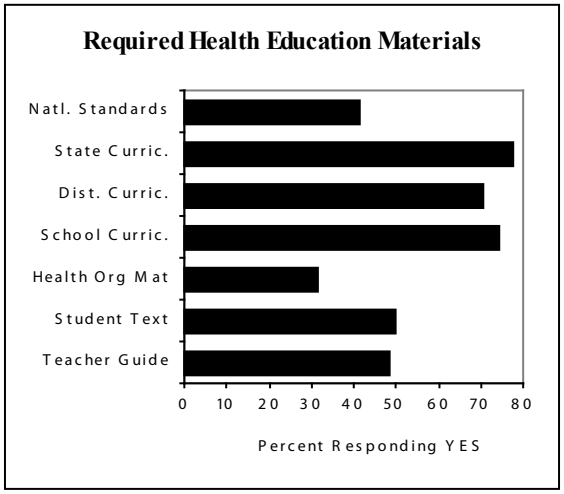
While more than half the principals reported that their schools require health education in grades 7 and 8, the percentage of schools requiring health education courses declines throughout grades 9 to 12. Fewer than ten percent of the principals reported that their schools require health education courses for high school juniors and/or seniors.

3. Very few secondary school students are actually exempted or excused from health education by parental request.



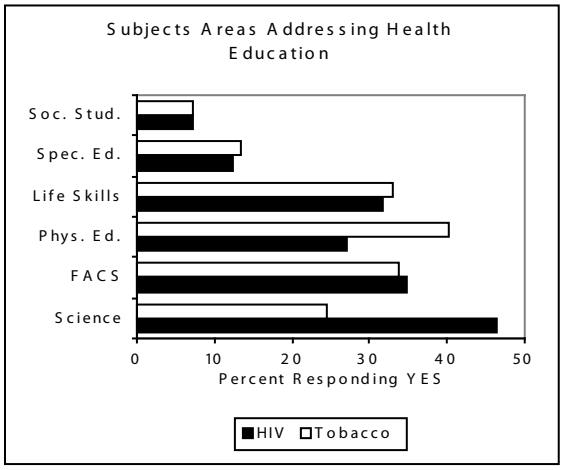
Although slightly more than half the schools permit students to be exempted or excused with parental permission, less than one percent of these students are actually exempted or excused from health education classes in the great majority of schools that actually permit exemption.

4. Most schools require that teachers use a state, school-level, or district-level curriculum to teach health education, and there is somewhat limited use of commercially prepared instructional materials.



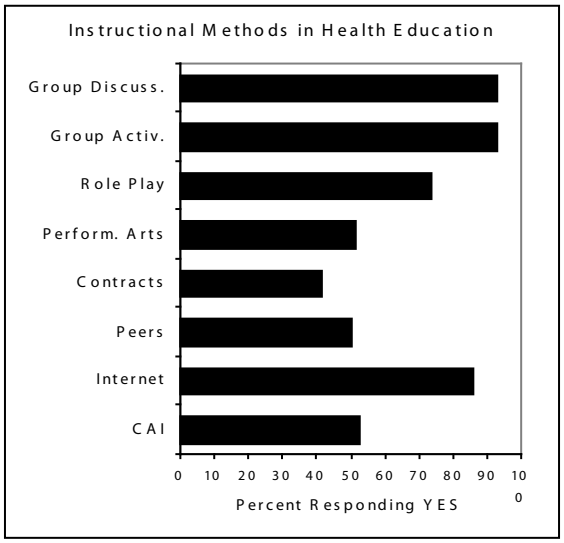
The greatest number of responding teachers indicated that they are required to use health curriculum developed by the state, district, or at the local school level; fewer than half these teachers are required to use a national-level curriculum. In addition, nearly half the teachers reported using a commercially prepared student text or teacher guide in a required health education class.

5. Required health education information, particularly tobacco use and HIV-infection prevention, is not well integrated into non-health classes except for physical education class.



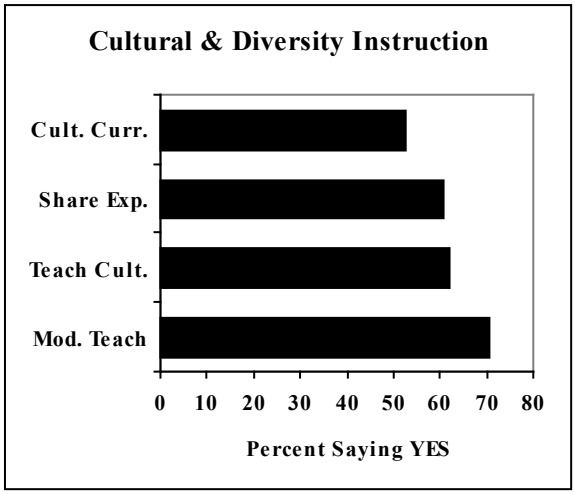
Only about one-fifth of the principals reported that required health education units or activities are taught in academic classes (such as science or social studies) outside of health education classes. Furthermore, fewer than half the teachers reported that tobacco use prevention or HIV infection prevention units or activities are addressed in any other subject area classes. Physical education classes, however, are the exception as general health education units and activities are taught in physical education classes in nearly three-fourths of South Dakota's secondary schools.

6. Teachers employ a variety of instructional strategies within the health education classroom, particularly those that involve group-related activities.



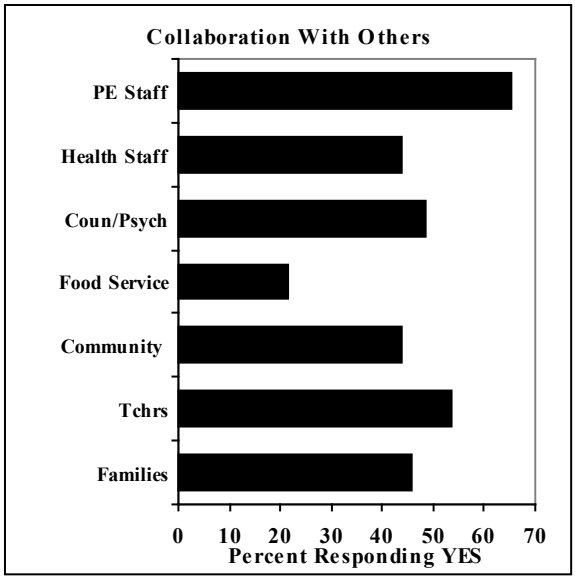
Group discussions and activities were reportedly employed by nearly all respondents. Additionally, more than half the teachers reported that they utilized numerous instructional strategies (including group discussions, group activities, role playing, performing arts, peer educators, Internet, and computer-assisted instruction) to teach health education to their students.

7. Teachers address diversity and cultural values to a reasonably extensive degree within health education instruction.



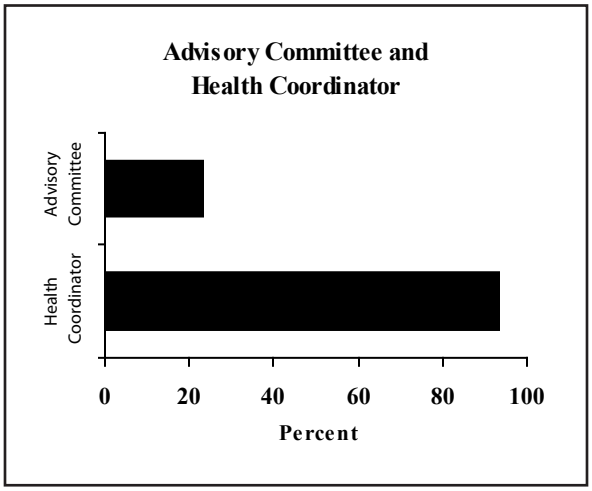
More than half the teachers reported modifying teaching methods to match students' learning styles, health beliefs, or cultural values, teaching about cultural differences and similarities, asking children to share their own cultural experiences related to health topics, and employing curricular materials reflective of various cultures.

8. There is a moderate degree of coordination of health education among teachers, other staff members, school health service staff members, and community members; however, parents and family members are afforded few opportunities to learn about the local health education program or classes.



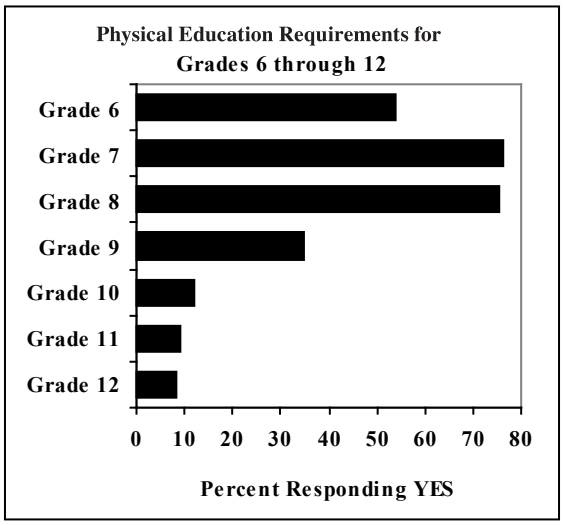
Approximately two-thirds of the teachers indicated that they had worked with physical education staff members, school psychologists or counselors and nearly half worked with school health service staff members, and community members on health education activities. However, less than half the same teachers admitted that they provided information to families about the school health education program and even fewer invited parents and/or family members to attend a health education class.

9. Schools and school districts make limited use of advisory committees in the development of health education policies or coordination of health education activities.



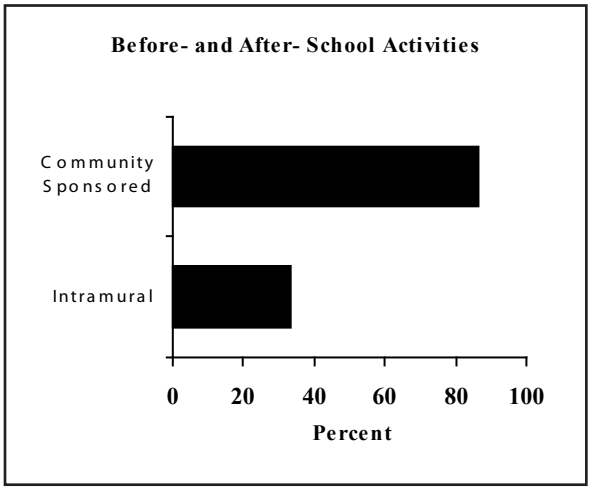
Less than one-fourth of the principals reported that their school or district has a health or advisory committee that develops policies and coordinates health education activities. However, less than 10% of the schools have no designated health education coordinator.

10. Required physical education courses are most prevalent during the junior high/middle school grades and diminish progressively throughout the high school grade levels.



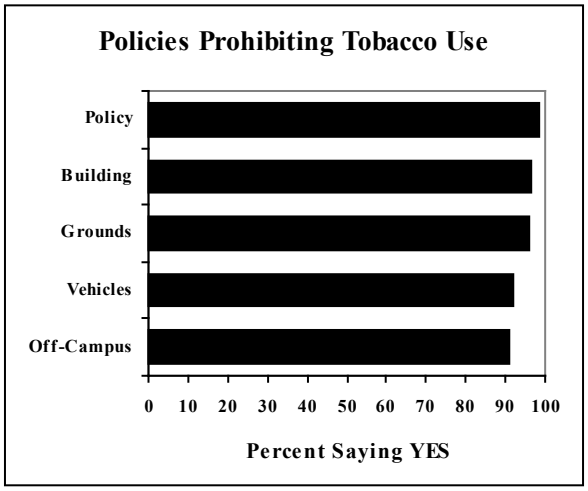
While more than half the principals reported that their schools require physical education in grades 7 and/or 8, the percentage of schools requiring physical education courses declines rapidly throughout grades 9 to 12. Fewer than ten percent of the principals reported that their schools require physical education courses for high school juniors and/or seniors.

11. Most secondary schools offer their physical education facilities to community-sponsored physical activity groups during non-school hours. However, schools provide limited opportunities and support for school-sponsored intramural activities outside of school hours.



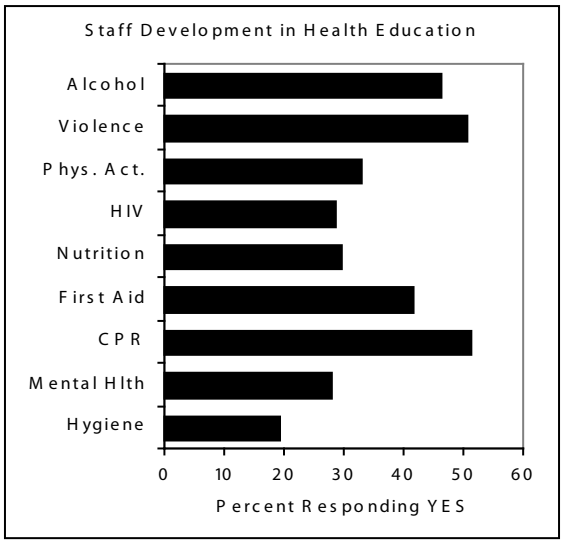
Principals from nearly nine schools out of ten report that community-based physical activity clubs and teams use their physical education facilities during non-school hours. In contrast, only about a third of the secondary schools in South Dakota offer students opportunities to participate in before- or after-school intramural activities or physical activity clubs and few of those provide transportation home for students who participate in after-school intramural activities or physical activity clubs.

12. South Dakota secondary schools are nearly uniform in their adoption of policies that prohibit student cigarette smoking and use of other tobacco products by students, faculty and staff, and visitors.



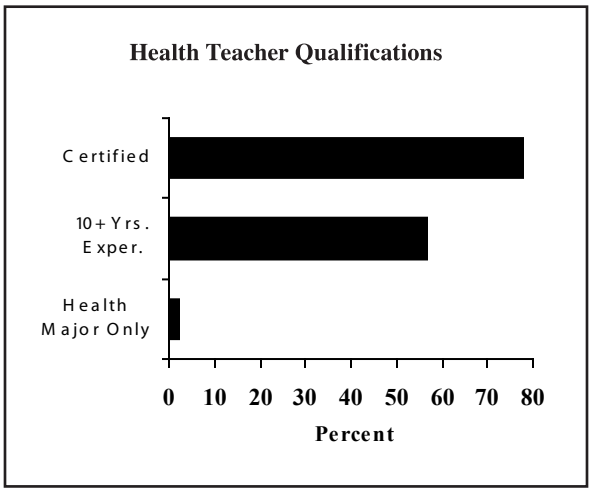
Nearly every secondary school in South Dakota has a written policy that prohibits students, faculty and staff, and visitors from smoking cigarettes or using other forms of tobacco (smokeless, cigars, and pipes). The great majority of these policies ban tobacco use in school building, on school grounds, in school vehicles, and at school-sponsored off-campus events. These policies also prohibit tobacco advertising on school property and prohibit students from wearing clothes and accessories that advertise tobacco company names and logos.

13. There are limited staff development opportunities for teachers related to health education topics or instructional methodologies.



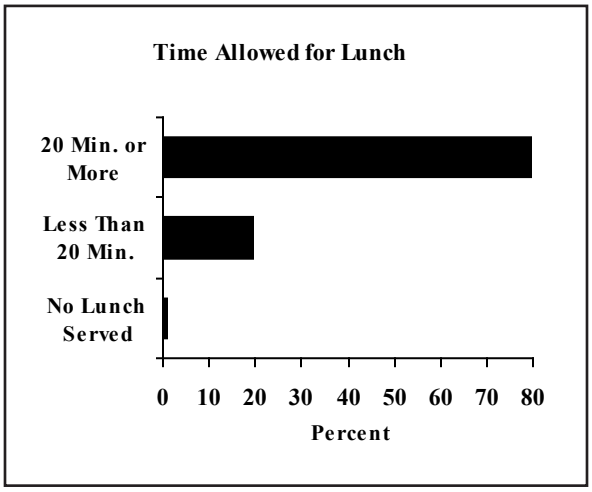
Aside from CPR and violence prevention, fewer than half the teachers have participated in staff development activities during the past two years related to any other health education topics. During that same period, fewer than half the teachers reported having participated in staff development activities focusing on specific teaching methods for the health education classroom. The health education topics that teachers would most like staff development to address include violence prevention, CPR, alcohol or other drug use prevention, and first aid.

14. Health education teachers in South Dakota are generally experienced and appropriately certified. However, very few health education teachers studied health education as their only major area.



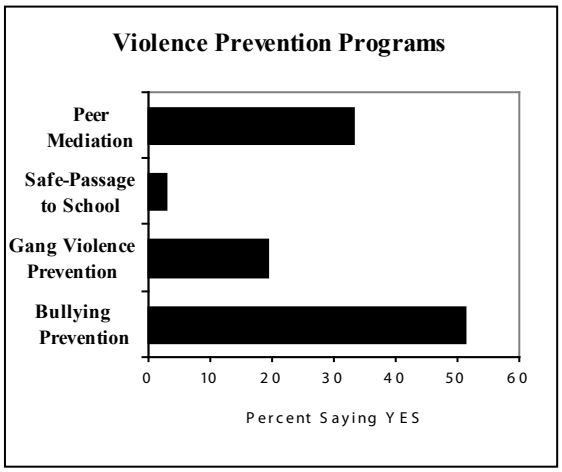
More than half the teachers reported that they had taught health education for ten or more years and over three-fourths hold health education certificates, licenses, or endorsements recognized by the state. While slightly more than half the teachers had professional preparation in health education combined with physical education, fewer than one teacher in 20 majored in health education alone.

15. While most schools provide sufficient time for students to eat lunch, many fewer schools take positive steps to assure that students eat nutritious foods.



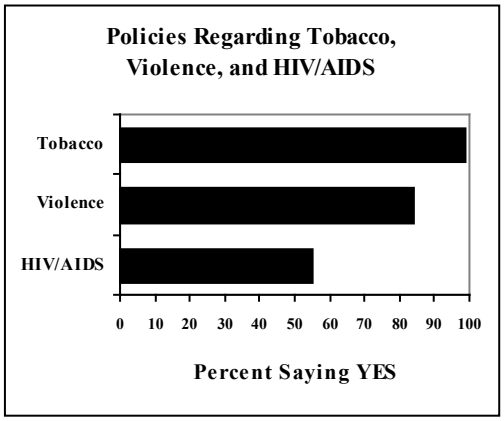
More than three-fourths of the secondary school principals reported that once seated their students have 20 minutes or more to eat lunch. However, fewer than one school in ten has a policy that fruits or vegetables will be offered at school settings other than lunch and many more schools offer candy and soft drinks than veggies and low-fat foods in their vending machines, school store, canteens, or snack bars.

16. Although most secondary schools have written plans for responding to violence at the school, far fewer schools participate in programs designed to prevent or reduce school violence.



Most of the principals indicated their school has a written plan for responding to violence at the school. Fewer than half of the same principals, however, reported that their school participates in a formal program (such as gang violence prevention, safe-passage to school, or peer mediation) designed to prevent or reduce school violence. Programs regarding bullying were the only exception to this trend.

17. Fewer schools have adopted formal written policies regarding HIV infection than have done so for tobacco use or violence prevention.



While nearly all South Dakota secondary schools have tobacco use policies and more than three-fourths have written plans for responding to violence, only about half the same schools have adopted a written policy regarding the rights of students and/or staff with HIV infection. Almost all the HIV infection policies that have been adopted, however, address issues of confidentiality, student attendance procedures, worksite safety, and protection from discrimination.

1. **Conduct activities that recognize school districts throughout the state that require secondary school students to take at least three or more health education courses and encourage the remaining school districts to initiate or increase health education requirements for their secondary students.** The South Dakota Department of Education (DOE) should formally recognize those school districts that currently require students to take at least three or more health education classes in grades 6 through 12. More importantly, efforts should be made to encourage those school districts that presently have little or no health education requirement for their secondary students to adopt programs and curricula that are similar to those presently employed in the district having more extensive health education requirements. In addition to DOE personnel, school administrators and/or health education coordinators/teachers from districts having more extensive health education requirements could be employed to assist other districts establish and/or expand their current health education programs.

   One specific area that should be considered is encouraging more schools and school districts to require health education throughout the upper grades in high school. As the great majority of required health education now occurs in grades 6 through 8, one area of encouragement should be to include at least one required health class during the senior high school grades. Health education courses required for older secondary students and the topics that comprise those courses could be tailored toward the needs and interests of older, more mature students.

2. **Conduct activities to promote the incorporation of national health education standards and continue to encourage schools to increasingly utilize South Dakota state-level health education standards and recommendations for health education instruction at the local (school and school district) level.** While teachers throughout South Dakota continue to rely heavily upon school and school district health education curricula and instructional materials, the utilization of state-level curricula has increased markedly during the past several years. While teachers should be encouraged to utilize locally developed materials, the importance of incorporating national and state standards and guidelines for health education instruction should be emphasized. School administrators and health education teachers should be encouraged to participate in professional development activities that expose them to national and state health education standards and present them with a model for incorporating those standards into their health education instruction.

3. **Recognize the many schools that require physical education, but continue to encourage more required physical education classes within the upper grade levels.** The schools that require more than three physical education courses should be recognized and applauded for their efforts, but should also be encouraged to require more physical education classes than they presently do. Particularly, schools should be encourage to consider making more physical education courses required for students in their sophomore, junior, and senior years.

4. **Conduct activities designed to promote the integration of health education, particularly tobacco use and HIV-infection prevention, into the broader secondary school program of study.** Presently, health education topics and activities, particularly those related to tobacco use prevention and HIV-infection prevention, are taught in non-health education classes to a very limited extent. In conjunction with the professional development activities cited in the previous recommendation, a rationale and a model for incorporating health education topics and activities into other academic subject areas should be presented to school administrators and health education teachers. The effective inclusion in physical education of topics related to tobacco use prevention and HIV-infection prevention could serve as a model for incorporation into other subject area courses.

5. **Utilize health education teachers who currently incorporate a variety of instructional methodologies to provide inservice training for their peers who would like staff development in this area or who have been identified by their administrators as needing such assistance.** The variety of instructional techniques and strategies that teachers report using indicates that some or many of them would be valuable role models or presenters at staff development activities for their colleagues who have yet to reach the same level of instructional effectiveness in health education. Contacting and orienting a cadre of experienced health educators willing to share their instructional expertise with colleagues would produce a valuable resource for the DOE.

6. **Develop and disseminate a model for effective involvement of parents and family members in their local secondary health education programs.** Conduct meetings with school administrators, teachers, parents, and local community members that highlight the importance of parental and family member involvement in the health education program and present a model or mechanism by which such involvement may be accomplished.

7. **Develop and disseminate a model for effective involvement of health education advisory committees in formulating health education policies and coordinating health education activities at the secondary school level.** Inherent in the concept of a "coordinated" health education program is the utilization of an advisory committee or group to assist local schools in developing and delivering health education; however, fewer than one in four South Dakota schools employs such an advisory committee. Conduct meetings with school administrators, teachers, and other stakeholders that highlight the importance of such advisory committees and groups and provide a model or mechanism by which local schools or school districts can establish and maintain advisory committees or groups.

8. **Provide professional development for teachers that focus on topics teachers identify as being of greatest interest.** Teachers in the present study indicated that during the past two years insufficient opportunities were provided for professional development related to health education topics or instructional techniques. They also identified violence prevention,

CPR, alcohol or other drug use prevention, and first aid as the professional development topics of most interest. Results of the present study should be examined as a starting point in determining potential topics for future staff development for secondary school health education teachers. As indicated in Recommendation 4 above, attempts should be made to identify and employ experienced health education teachers to conduct these workshops or activities that address topics and instructional strategies of interest.

9. **Conduct activities designed to encourage secondary schools to adopt formal violence prevention programs and provide a model by which such programs could be established and implemented in the secondary schools.** Although many schools have written plans for responding to school violence, few of them have implemented formal programs that have been demonstrated effective in the prevention and reduction of school violence. Conduct meetings, utilizing experts in the field whenever possible, to familiarize school administrators and teachers with some of these recognized violence prevention and reduction programs, and encourage them to adopt one or more of these programs for use in their own school.

10. **Recognize the many schools that offer their facilities to community-based groups during non-school hours but strongly encourage school to provide expanded school-based opportunities for before- and after-school intramural activities.** The many schools that open their facilities to community-based groups should be applauded, and mechanisms for expending these already prevalent programs should be sought. However, concerted effort should be made to expand the number of schools that sponsor before- and after-school intramural activities or physical activity clubs and encouragement or incentives provided for schools that provide more support such as transportation to and from these activities.

11. **Develop and disseminate a model to encourage and assist schools to offer more nutritious foods and drinks to students throughout the school day.** The state should coordinate efforts among comprehensive health agencies and other food providers to strongly encourage schools to develop policies and facilitate access to healthy foods (such as veggies and fruits) throughout the school day. The importance of balanced meals and healthy snacks should be integrated into health and science classes in secondary schools, and schools should be provided assistance in developing and implementing policies that assist students to eat and snack on healthier foods throughout the school day. Schools that permit students access to vending machines during the school day should be encouraged to examine these policies and those choosing to continue making vending machines available should be encouraged to advocate that their students make healthier choices in the vending machine

foods and beverages that they purchase.

12. **Develop and disseminate HIV infection/AIDS policies that schools could adopt and implement, and provide professional development activities for administrators and teachers highlighting the importance of having written HIV infection/AIDS policies.** Although many schools have adopted tobacco use policies, far fewer schools have written HIV infection/AIDS policies in place. Schools that have not yet adopted written HIV infection/AIDS policies should be encouraged to do so and sample policies should be provided that have been effective in other schools. These schools should also be targeted for professional development activities focusing on the importance of written HIV infection/AIDS policies and how they are implemented at the school and district levels.

13. **Provide adequate resources for targeted improvements in school health education programs.** The state must provide sufficient resources in the form of grants, loans, funding, and up-to-date curricular materials to enable schools and districts to implement the programs and activities presented through professional development activities.

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